



HealthNet Annual Report 1998

AFGHANISTAN: KABUL, NANGARHAR PROVINCE, EASTERN AND SOUTHERN REGIONS, NORTH-WEST FRONTIER, FEDERATION OF BIH: CANTON OF SARAJEVO, ZENICA-DOBOJ, MIDDLE BOSNIA, REPUBLIKA SRPSKA, KOSEVO HOSPITAL, SARAJEVO, CAMBODIA: BANTEAY MEANCHHEY PROVINCE, SVAY RIENG PROVINCE, ETHIOPIA: AKAKI-KALITI AREA, ADDIS ABABA, SOUTHERN ETHIOPIA: WEST GEORGIA: TBILISI AND ACHARA, MOZAMBIQUE: NAMPULA PROVINCE, PAKISTAN: PUNJAB AND BALUCHISTAN PROVINCES, PERU: DEPARTMENT AYACUCHO, PROVINCES FAJARDO AND VILCAS HUAMAN, ROMANIA: IASI, RWANDA: KIGALI, SOUTHERN SUDAN: BAHR EL GHAZAL, LAKES, EASTERN AND WESTERN EQUATORIA, JONGLEI, UPPER MERU



Annual Report 1998



Foreword

In 1998, Cambodians faced the anxiety of elections and subsequent violence on the streets of Phnom Penh; Ethiopians saw a fresh war in Eritrea; Bosnians witnessed the slow deterioration of the Dayton peace agreement and rising tensions in Kosovo and Afghans lived with the continued conflict between the Taliban and the old Mujahedeen forces. At the same time, Georgians faced more anarchy; Rumanians lived with increasing poverty; the Sudanese saw no relief from decades of war and famine, and those living in Central America witnessed the sheer destructive force of nature.

People in all these countries have lived for years, sometimes decades, in societies torn apart by war. Families struggle to care for their children and the elderly while recovering from the effects of war, loss and the new crises that often follow. While they face the uphill battle of personal recovery, it is vital that their society as a whole and its institutions are rebuilt as well.

Every day we witness the remarkable resilience of the people in those countries where we work. Most people manage to keep their families together and to take care of each other. They have suffered, and suffer still, but should not be victimised. They are survivors. Systems, structures and often the whole fabric of their society have been destroyed around them and yet they have survived. Their energies are taken up almost exclusively to that survival and there is little left to tackle the huge task of rebuilding institutions and systems.

Functioning and effective health care structures are essential to this process of rehabilitation. Both because people need to be healthy to rebuild peaceful and productive lives, and because creating environments of care is the core of rebuilding trust within a community. And trust is the basic element in restoring the peace.

Health care systems, particularly, take dedication, knowledge, skills, material means and time to redevelop. It is here that external support is both needed and welcome. HealthNet International works to support these people in the process of developing or rebuilding their systems of health care. This can be in situations where functioning care systems never existed, in disintegrating states or where populations face a transition to unknown new situations.

In 1998 HealthNet International continued this work, and at the same time reviewed its own functioning as an organisation. This made 1998 a year of transition for HNI itself. In this case, however, it is clear where this transition leads us. It leads to a more clear relationship with the main partner, Medecins sans Frontieres Holland. It leads to a restructured office, new projects, the development of new interventions and networks, and it leads to growth.

In an environment of weak states and global economic interests crises are still becoming more complex. HealthNet faces the challenge to translate its growing experience in the area between emergency and development to appropriate interventions in a wide range of circumstances. In 1998 we

have prepared ourselves for this task, by developing the new alliance with MSF-Holland, reviewing the office structures, and assessing the role of HNI in complex emergencies. At the same time we continued our projects in 10 countries.

We look forward to implementation of these new structures in the coming years.

On behalf of the board

A handwritten signature in black ink, appearing to read 'Y Baune'.

Yvonne Baune
Chairman

HealthNet International

Mission Statement

Purpose

HealthNet provides assistance to people in rebuilding or adapting their health care system in contexts of complex crises. HealthNet activities start from the conviction that all citizens of the world are bound by solidarity to all other people, regardless of their creed or whereabouts. People living in unstable contexts, coping with the effects of conflict, natural or man-made disaster, are vulnerable but at the same time often show surprising resilience. HNI addresses this vulnerability and resilience in assisting people in developing, rebuilding and managing their own systems of health care. Using a holistic definition of health, HNI strives for healthier individuals, groups, and communities. The goal is to enable people to make their own decisions and act upon them. Respect for human rights and local culture are preconditions for any acceptable public health system. HNI works with the local population to develop creative solutions for the potential tension between these values.

Helping people to help themselves

HealthNet specialises in helping people to help themselves, and supports them in developing the capacity needed to make the changes they want. HealthNet activities are therefore undertaken in collaboration with local partners.

The emphasis is on strengthening the resilience and effective coping styles in individuals, groups and society. The people that are coping with the effects of conflict and chronic instability are actively involved in developing and managing their own appropriate health system and gaining access to state services.

The presence of HNI is defined by the needs of the population. HNI comes in at the request of governments, organisations, or the people themselves. HNI strives to use local, regional and global networks of professionals to match the human resources locally available. Sustainable capacity building is an important aspect of the intervention. Working with local capacity and expatriate involvement is carefully balanced in the process of installing self-reliance. The commitment in time and professionalism is reflected in working with senior, experienced and professional staff.

Approach

Networking is at the core of the HNI approach: locally, regionally and internationally. HealthNet is committed to accountability towards all stakeholders in the process of assisting people: the donors, strategic and implementing partners, and not least to the populations HNI works for. Partners include local organisations, international

implementing agencies and academic institutions in different countries with higher or lesser degrees of industrialisation. Partner organisations are to be found in the field of emergency organisations (a special strategic alliance with MSF-Holland), as well as the fields of science and development. The professional skills of these partners help HNI to offer the best possible assistance, in a wide range of specialisations, to people who are reshaping their society and their health systems. At the same time, this network is helpful to disseminate information of relevance for advocacy and continuous improvement of strategies for help in complex emergencies.

HealthNet in 1998

1998 has been a year of transition for HealthNet in many ways. HealthNet International originated in 1992 out of MSF Holland. It was a response to the need to create appropriate answers to the needs in complex emergencies. Bridging the gap between relief and development requires an appropriate response. HealthNet took over projects from MSF Holland, and developed these projects further according to the needs. Throughout the years, HealthNet gained more expertise in various 'post-conflict' settings, and in the practicalities of taking over projects.

The post-cold war years taught that weakened states in an international power-vacuum can give rise to local conflicts that follow different lines and include different risks than was conceivable in the era of power-blocks. Long-term slumbering conflict can suddenly erupt in violence, then seemingly cease to be relevant, and suddenly re-erupt with a vengeance. Afghanistan, Burma, Burundi, Ethiopia, Indonesia, Rwanda, Somalia, Sudan, and Sri Lanka are examples. The so-called 'grey zone' between relief and development needed rethinking. There is no simple chronological order between emergency, relief, and development. HealthNet needed to rethink its mandate in the context of complex situations, and accordingly reconsider the practical relationship with MSF-Holland.

In early 1998, the International NGO Training and Research Centre (INTRAC) assessed the relationship and future potential of collaboration between HealthNet and MSF-Holland. The boards of both HealthNet and MSF-Holland adopted the "Alliance Option" that was proposed by the assessors. The two

organisations are now working towards a special partnership, a strategic alliance, which enables each of the two organisations to respond more adequately to the complex crises in the world today. A complementary approach to complex emergencies within a strategic alliance will lead to results that are more than the sum of MSF and HealthNet interventions.

Reflecting this new phase in its existence, the board of HealthNet rearranged itself. After having guided HealthNet International through most of the first seven years of its existence, Mr Peter Meyer Swantee handed the responsibility of the chairperson over to Mrs Yvonne Baune. She will guide HealthNet International through the phase of independent partnership in the new alliance. To the benefit of HealthNet, Mr Peter Meyer Swantee's experience will be preserved for the organisation in his position as vice-chairman. The director, Dr Egbert Sondorp, left the organisation in February to pursue other goals abroad. Mr Vincent Faber took over as interim director and successfully steered the organisation towards October, when Mr Willem van de Put started as the new HealthNet International director.

Amidst all this change and planning HealthNet International continued its activities in 10 countries. Assistance is given with the aim to help local people, organisations, or governments in establishing appropriate, accessible, reliable, affordable and effective health services. In periods of transformation, the necessary staff to design and implement appropriate interventions may need to be recruited

internationally. HealthNet International strives to create cross-country networks of local experts. Working on another way of integrating international expertise with local experience; HealthNet International creates networks of trained people who are willing and able to contribute to interventions in various countries.

Internal organisation

Following the assessment done in the beginning of 1998, HealthNet started to design its plan for the future. In order to develop further as an interdependent organisation, HealthNet strives to reach a volume which secures the commitments made to target populations. These commitments entail financial stability, a continuous pool of expert human resources to draw from, and well established links with centers of expertise to back up adequate response to public health challenges in complex situations. Managing about 30 projects with a yearly turnover of about Hfl 25 million is believed to be a critical mass for HealthNet International: big enough to safeguard commitments made, and small enough to remain innovative in its approach. In the next four years, HealthNet International will strengthen its quality in the office, in the field, and in the operational availability of its networks in order to reach these goals. In a strategic partnership with MSF-Holland, HealthNet International will develop implementing partnerships with centres of specific expertise around the world.

The role of the office vis-a-vis the projects will be reviewed, with an emphasis on support rather than control. To further capacity building in the field, responsibilities need to be carefully delegated. International as well as locally recruited staff will be supported in professional development. Conditions of service as offered by HealthNet International will be checked for competitiveness. Working with local capacity and networks should be more than an empty statement. The assessments presently undertaken need to look into the option of recruiting local staff and working with existing local organisations. Regional networks need to be installed and managed by people with excellent knowledge of the local context.

Projects

At the beginning of 1999, HealthNet International had 13 projects. During 1998, HealthNet International sent 40 expatriate professionals from 15 nationalities to 12 countries. All projects are set in a context of complex crises. In some areas, conflict is continuing, in others, a process of reconciliation seems to result in steps towards a more stable situation. This poses some special challenges to the implementation of projects.

Identification of effective and reliable counterparts becomes a special strategic choice in a situation where there is no clear view on who local and national authorities are. Donors are interested in the concept of working between emergency

response and development co-operation. The need is seen, but the funding mechanisms have often not yet been properly adapted. HealthNet's expertise is offered in the debate on new models for the international community's response to complex crises.

In these complex situations that form the background to HealthNet's activities, counterparts have to cope with the consequences of severe social disorder. Psychosocial problems are prevalent in all project sites. It remains important to realise that all populations we work with need to come to terms with the past. This applies to the 'target population' but also to individual counterparts in the projects. A specific awareness of this situation helps in understanding some of the problems in project implementation, and leads to an emphasis on the reconstruction of trust in communities and societies we work in.

A participative stance in the development of civil society and human rights issues is the next step. In the HealthNet approach, working with and through the population in unstable situations includes the aim to contribute to self-reliance. HNI strives to assist people in regaining improved control over their own fate.

In Afghanistan, a health care system supported by the local population is being established in a way that challenges the black-and-white views on working in unstable areas. The Malaria Control programme in Pakistan and Afghanistan is beginning to develop into a regional center of excellence. In

Cambodia, the expertise of HealthNet International in implementing health reform on district level is recognised by the Ministry of Health and the Asian Development Bank, who granted a new project to HealthNet International. In Peru, villagers begin to build trust after years of fear of the Sendero Luminoso. In South Sudan, HealthNet supports 31 NGOs in the battle against river-blindness. In Ethiopia, health care for the displaced around Addis Ababa was further developed, and preparations started for the work in Beni Shangul. In Mozambique, co-operation with four districts in Nampula resulted in extension of the project. In Rwanda HealthNet supported rehabilitation care for victims of the genocide, and in Rumania a local organisation was further developed. In Bosnia psychosocial support was further integrated in the national health system.

The plan is to extend considerably, in order to reduce vulnerability of the organisation and its projects (spread risks), to better utilise capacity at the central office, and to create the conditions for change. New projects offer the possibility to make a fresh start in human resource policy, project management, and raising the profile of HealthNet International. Assessments are underway in Eastern Europe and the former Soviet Union, the Great Lakes area, and Central America.

In the Great Lakes area, an assessment will lead to a clear strategy for HealthNet International. The strategy defines the projects. An example in Rwanda is the need for a long term psycho-social rehabilitation programme. Health reform is

another issue in the region, and HealthNet International will be pro-active in its approach towards the different levels in the different countries, as well as donors.

Presently HealthNet and MSF-Holland are assessing the options of extending a successful approach to AIDS/STD prevention in Russia, the Ukraine, Mongolia, Georgia and perhaps other parts of the former Soviet Union. MSF-Holland developed an approach in Russia that is now requested by other states. The idea is that HealthNet International takes over the existing project, and works towards locally appropriate interventions based on the tested modules in Russia.

In Central America a whole range of projects is presently formulated, following joint assessments of HealthNet International and MSF-Holland. The hurricane Mitch disaster showed the need to strengthen local organisations in emergency preparedness.

Finance

Through 1998 the organisation has continued to grow in terms of overall income and expenditure. Income has increased by 26% to NLG 10.4 million and expenses by 21% to NLG 11.2 million.

In 1998, support from the Netherlands Government has increased significantly. Support for the program in Angoshe, Mozambique was renewed with a three-year grant.

Furthermore we have received new grants for programmes in Bosnia, Afghanistan and Cambodia. Netherlands Government grants made up 38% of all new grants signed in 1998. The work of HealthNet is made possible by institutional donors such as the European Union, The Government of the Netherlands, MSF-Holland, ICCO, and private grants. Substantial private donations were received from 'Stichting OPTIMIX' and VISIO. The latter supports the river-blindness project in South Sudan. These private contributions have not only helped the beneficiaries, but also strengthened the morale of the HealthNet teams.

In October 1998 HealthNet successfully tendered for a contracted four-year pilot project "Basic Health Care" in Prey Veng district in Cambodia. The contract, signed in December between HealthNet and the Cambodian Ministry of Health, is financed by a loan from the Asian Development Bank. This tendering procedure is a novelty in Cambodia. Commercial organisations were excluded in favour of non-profit NGO's with a track record in Cambodia. In itself this procedure shows a new trend in the funding of humanitarian work. Next to funds received from a typical emergency donor such as ECHO, this pilot tender shows the variety as well as the potential confusion in the area between relief and development.

One of the outcomes of the assessment of HealthNet as an independent, allied partner of MSF-Holland, is that HealthNet will review its fund-raising strategy. In the course of 1999, a beginning will be made with the development of a new strategy. The challenge will be to secure sufficient private

funds to cover indirect project costs. These indirect costs were reduced further in 1998 to somewhat less than 12%.

Outlook for 1999

Throughout the years HealthNet has developed a growing expertise in identifying needs in populations at risk. Catering for these needs is often delicate, since the context is in the 'grey zone' between open conflict, recurrent violent outbreaks, and sustainable rehabilitation. HealthNet was created to work in exactly this context. Health systems (re)development, strengthening coping and self-reliance, and working with local capacity are key elements in HealthNet's work.

In the coming years, HealthNet enters a new phase in its relation with MSF-Holland. The foreseen alliance aims at improving the delivery of quality assistance for populations in danger in various stages of the cycles of violence. HealthNet has started the process of reshaping itself in order to face this challenge. Learning from the combined experience of HealthNet as an institute and the experience that exists in the many groups of survivors we have come to know, we try to fulfil the moral obligation to come up with better answers for people living in conflict zones and disaster areas.

Projects

1998



Afghanistan

Fighting a destructive disease

Kabul, the capital of Afghanistan, is a city in ruins. After years of conflict, little remains that has not been destroyed, looted or badly damaged. Those who have not fled the city live in abject poverty with little in the way of sanitation or health services and only sporadic supplies of food, fuel and shelter. Such services as did exist were provided by non-governmental organisations. These too came to an abrupt end when most organisations were finally forced by the Taliban rulers to abandon the city in the middle of the year.

Any prospect of recovery in the city is a long way off. The conditions are ripe for epidemics and it is no surprise that the last four years have seen an explosion of cutaneous leishmaniasis. Transmitted by the simple bite of a sandfly, leishmaniasis causes chronic ulceration that eventually heals to leave scarring and deformity, especially on the face. The disease brings with it a strong social stigma with many sufferers finding themselves excluded even from their own families. Treatment is expensive and time consuming and existing clinics have few resources. Monitoring and prevention strategies are non-existent.

HealthNet surveys conducted in 1997 showed that 30% of the poorest communities and 5% of the overall population of 1.2 million people in Kabul have active leishmaniasis.

Providing protection against the sandfly bite is the primary means of prevention. Male and female Ministry of Public Health staff, trained and supervised by HealthNet, worked with the worst affected communities promoting the use of bed-nets and the spraying of houses with insecticide. Both methods proved very popular with the communities and highly effective with over 200,000 people receiving some protection. Surprisingly, in a city where in theory women are not allowed on the streets, the majority of those buying bed-nets were women.

A specialised treatment centre, set up in the most densely populated area of the city in collaboration with the Ministry of Public Health, also proved very successful. Over 2,500 new cases had been treated in 1998 before HealthNet, like all other NGOs in Kabul, was forced to interrupt its operations. Priority

PROJECT TITLE Leishmaniasis control programme in Kabul

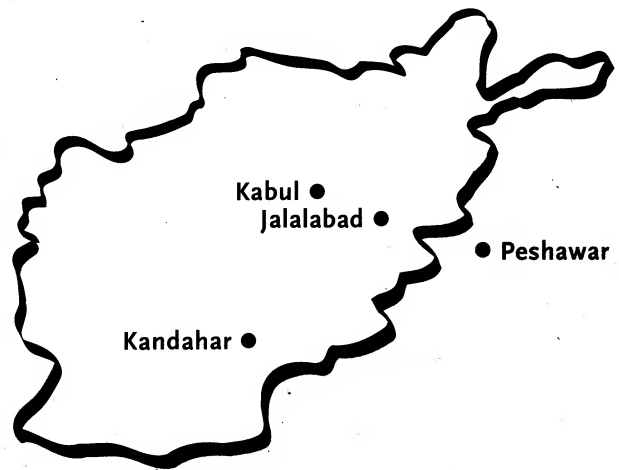
LOCATION Kabul, Afghanistan

START DATE December 1996

TARGET POPULATION Local population of Kabul – approximately 1.2 million

PARTNERS Ministry of Public Health, WHO, WFP, Pharmaciens Sans Frontieres

FINANCED BY Norwegian Church Aid, ECHO



was given to the most severely affected patients and to those in the early stages of the disease with equal numbers of men and women being treated despite increasing restrictions on female staff.

Following two visits by a joint HealthNet/WHO consultant in December 1997 and May 1998, HealthNet's team produced standard guidelines for treatment which have been accepted for use by all those involved in health in the city.

HealthNet also conducted an in-depth study on the devastating social impact of the disease. With many people wrongly believing that it is transmitted by personal contact, those suffering from the disease are ostracised. Men are excluded from work or social contact and women forbidden to fulfil their normal domestic role of cooking, cleaning and child care. Clearly, the suffering and economic burden of the disease could be dramatically reduced through an effective and appropriate health education campaign. Establishing a center for the treatment of a disease with obvious social impact adds to the normalisation of daily life in war-torn Kabul.

Despite the abrupt interruption to the work, much of it continues to have an impact. Suffering of patients has been reduced or avoided altogether through treatment and prevention. HealthNet is continuing to support the dedicated Afghan staff who have remained in their posts. The staff keeps the clinic operational, and we look forward to resume the prevention and capacity-building efforts.



Afghanistan

Improving the quality of health care

After over 20 years of war, Afghanistan is still not completely free of conflict. However, with the Taliban now controlling over 90% of the country, relative peace and security is now being re-established in many areas.

At the same time, there is no real functioning civil administration and many local professional people have fled the country. In fact, the country has been completely devastated to the extent that the population has had to become totally dependent on external support.

Just 2 % of people have access to health services, 13% to adequate sanitation and 23% to safe drinking water. Infant and under-5 mortality rates are high and maternal mortality, at 1,700 per 100,000, is the second highest in the world. Pregnancy and labour are considered risky for Afghan women due both to the high fertility rate and to the fact that trained health personnel attend just 9% of births. Mother and Child Health services themselves reach less than one third of the female population. Overall, quality health care, low as it is, is poorly monitored and badly managed.

Difficult and unexpected funding problems for the Health Care Support Project in 1998 meant that HealthNet could not implement any new expansion activities in the cluster districts.

Instead, HealthNet had to rely on funds remaining, cost sharing income, contingency funding and community contributions to continue its existing work without compromising the high quality of the health care. This has focused on the Ghani Khel rural hospital, six Basic Health Centres, two clinics and two Health Sub Centres. Having to deal with this temporal set-back emphasised the value of the programme as a model for filtering effective styles of participation of people in their own health care system.

Supervision and monitoring took place at the district level through the Cluster Health Management Team, a management structure established by the project. At the community level, 26 Traditional Birth Attendants (TBAs) were trained and are now working in their villages alongside the 53 TBAs and 83 Village Health Volunteers who have already undergone the training. The community itself contributes up to half the cost of medicines and pays other fees for services. Donations in kind obviously proved crucial to the sustainability of this project.

PROJECT TITLE Health Care Support Project, Eastern Region, Nangarhar

PARTNERS Ministry of Public Health, United Nations Agencies, Non-governmental Organisations

LOCATION Nangarhar Province, Eastern Region, Afghanistan

FINANCED BY MSF Holland, European Union/DGI, Dutch Government, German Agro Action, UNDCP, UNHCR and WHO

START DATE September 1995

TARGET POPULATION

* Populations of six districts and internally displaced living at Hesar-hahi camp – total approximately 350,000 people.

PROJECT STAFF At the end of 1998, there were 350 staff working on the project, of which 98 were female.



*For the Obstetrics and Gynaecology and Paediatric units of the university hospital, the target population is all three provinces with a population of 2,200,000.

It is crucial for a project of this type to have good links with other partners working in different but relevant fields. HealthNet therefore continued to establish and strengthen existing links with those involved in areas such as food security, water, physiotherapy and disease control.

In August 1998, HealthNet began its support to the Obstetrics and Gynaecology unit of the university hospital in Jalalabad city. There are only three hospitals offering obstetrical care in the Eastern region, two of which are run by non-governmental organisations and faced many funding difficulties. As a government unit, the university hospital was also working with severe financial limitations. However, with HealthNet's support, financed by the Dutch government, it is able to offer high quality specialised care to the women and children in the region. The support also ensured an ideal working environment for the female unit staff and the unit's performance showed a marked increase. A cost-sharing scheme has been introduced to ensure sustainability in the future.

Following the phase out of the Help Afghan Foundation at the end of the year, HealthNet began providing similar support to the hospital's Paediatric unit, the only such unit for children in the entire region.



PROJECT TITLE Providing community-based mental health services in post-war BiH

LOCATION Federation of BiH: Cantons Sarajevo, Zenica-Doboj, Middle Bosnia

START DATE April 1998

TARGET POPULATION All those with war-related trauma and other psychosocial problems

PARTNERS Cantonal Ministries of Health

FINANCED BY Dutch Government, MSF Holland

Bosnia-Herzegovina

Healing the mental scars of war

Elections held in September 1998 revealed the different concerns of the people, with more tolerant voting in the Federation but increased support for nationalist parties in the Republika Srpska and Croat pockets.

While there is increasing freedom of movement throughout the country, incidents of violence and harassment between ethnic groups continue and there violence occasionally flares up, particularly when refugees and displaced people return. During 1998, the problems have increased with the influx of tens of thousands of new refugees from Kosovo.

Mental health experts estimate that over a million people in Bosnia & Herzegovina (BiH) are suffering psychological trauma. Until now there have been no adequate services capable of dealing with the vast number of war and post-war related problems. The conflict itself saw health care facilities destroyed and many health professionals flee the country. What remains today of the pre-war drug-focused mental health care system has proved insufficient.

Currently the whole health system is in a process of reform and rehabilitation but progress is slow and mental health care is not considered a priority. In 1996 the World Bank started a project aiming at the establishment of 38 Community-Based

physical as well as psychosocial Rehabilitation centres (CBRs). Especially the development of functional psychosocial CBR centres proves seriously problematic and the first centres only began to operate in early 1998.

Although most of the CBR centres have now been reconstructed and equipped, it will take a long time before the centres will be able to meet the needs of the population because of limited resources, such as an appropriate budget, qualified staff, expertise and equipment meet the needs of the population.

In 1998, HealthNet took over a mental health project developed by MSF during the war from 1994 onwards. The project provides counselling services through ten centres in Sarajevo, Zenica-Doboj and Middle-Bosnia. Most centres also provide outreach activities to more remote areas where people, especially refugees, have no access to adequate mental health services. Since the hand-over to HealthNet, over 4,000 new cases have been taken on; about half are children.

PROJECT TITLE Strengthening Community Mental Health Centres in BiH

LOCATION Federation of BiH and Republika Srpska

START DATE April 1998

END DATE March 1999

TARGET POPULATION Staff of 40 Community Mental Health Centres

PARTNERS Ministry of Health, MSF Belgium, Caritas Denmark, SWEBIH, WHO

FINANCED BY ECHO, MSF Holland

PROJECT TITLE Improving psychosocial care for paediatric patients in hospitals in BiH

LOCATION Kosevo Hospital, Sarajevo

START DATE August 1998

TARGET POPULATION Paediatric patients in Kosovo Hospital

PARTNERS UNICEF, Wilhelmina Ziekenhuis Utrecht, Paediatric Association for BiH

FINANCED BY UNICEF



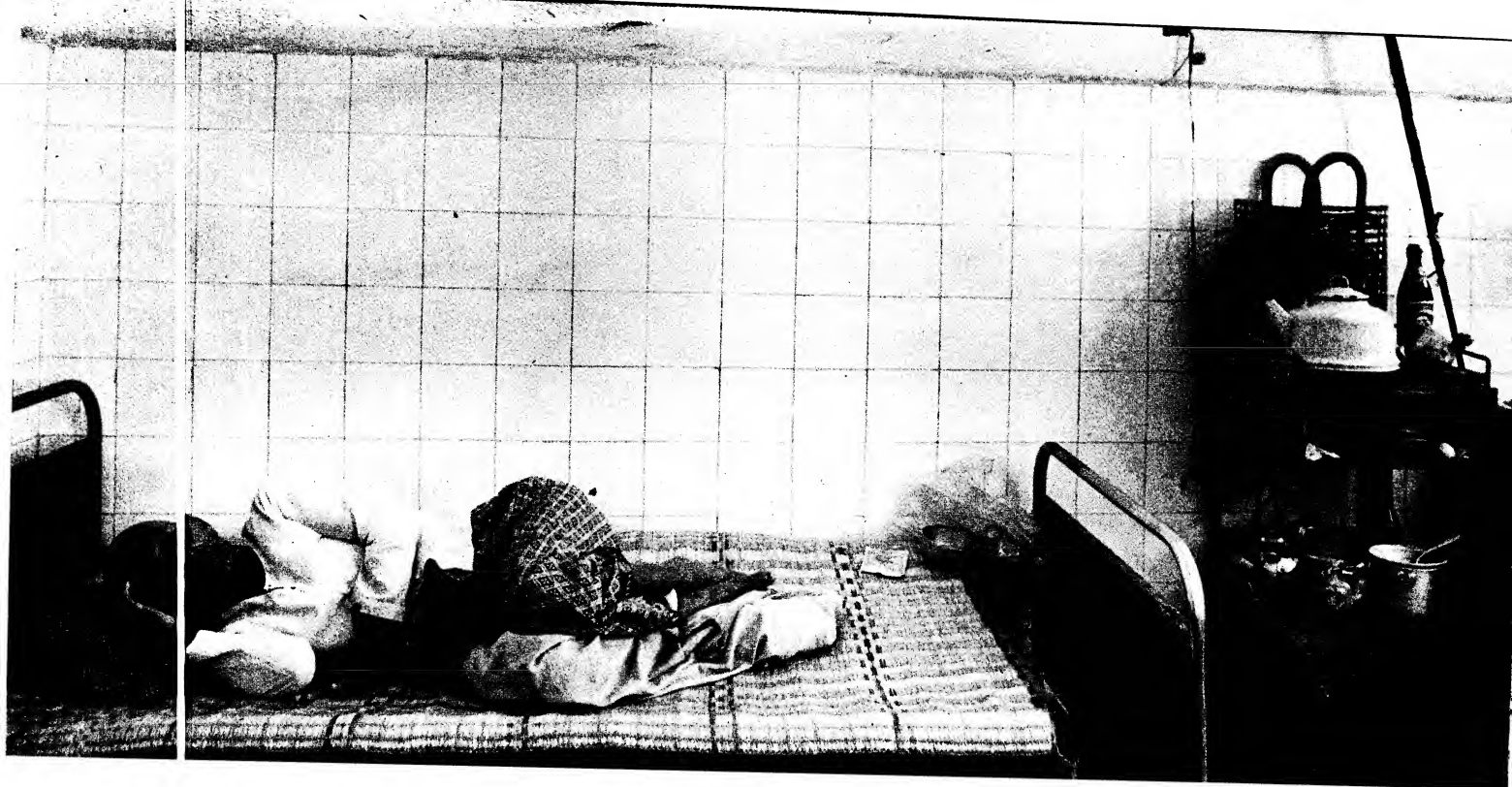
Apart from providing counselling services, it is also important to promote a much wider awareness and understanding of the symptoms and effects of trauma and promote coping mechanisms. Therefore staff members organise psycho-educational activities in schools, hospitals and other institutions and radio broadcasts on trauma and related mental health topics. Both clinical and management training is also provided to the staff of the counselling centres.

A monitoring system, set up and supervised in collaboration with the University of Utrecht, provides valuable epidemiological data on the psychosocial and mental health problems in Bosnia as well as on the output and impact of the centre.

The process of integrating the project into the formal health system began in 1998 and will continue in the coming years.

September 1998 saw the launch of a nation-wide mental health training programme. Co-ordinated by HealthNet, the aim is to provide relevant training to the majority of the 400 staff members of the CBR/Community Mental Health Centres in both the Federation of BiH and Republika Srpska. Organised in close co-operation with the Ministry of Health, the Federal Mental Health Expert Group and several international organisations, the training involved over 30 national and international training experts. The project is funded by ECHO, who will also support a follow-up on the training between April and October 1999.

A three month pilot project to improve the psycho-social care of young children in hospitals was launched at the Kosevo Hospital in Sarajevo in August 1998. Working in partnership with UNICEF, the Wilhelmina Hospital in Utrecht and the Paediatric Association of BiH, HealthNet will extend the project to five more hospitals over the next two years.



Cambodia Banteay Meanchey

Providing vital health training and education

Several decades of war, have left Cambodia's infrastructure badly damaged, its social and economic situation seriously hampered and its people decimated. In the north-western provinces, long plagued by insecurity and political infighting, the real need for humanitarian assistance is particularly marked. Here, too, the population live with continued disturbances of the resistance forces who joined the Khmer Rouge in the forests after the elections.

Cambodia's infant mortality rate is extremely high, mainly due to dengue haemorrhagic fever, acute respiratory tract infections, diarrhoea and vaccine-preventable diseases. With infectious diseases such as tuberculosis and malaria also prevalent, adult morbidity and mortality rates are equally bad. Women particularly are at risk with numerous and close pregnancies, malnutrition and poor hygiene practices commonplace.

HealthNet has been active in Banteay Meanchey since February 1996 with the aim of ensuring that government

health staff are able to provide quality health care and to help the people improve their health. Intensive training to health care staff and the rehabilitation or building of health centres are the two core means of achieving this aim.

The year saw the construction of a further two health centres and the transition of two former district hospitals to become health centres. The six HealthNet supported facilities in total are running well and providing vital services to the communities.

CAMBODIA – BANTEAY MEANCHEY

PROJECT TITLE 'Step by step –
together on the road to health' –
Supporting Public health services

LOCATION Banteay Meanchey
Province

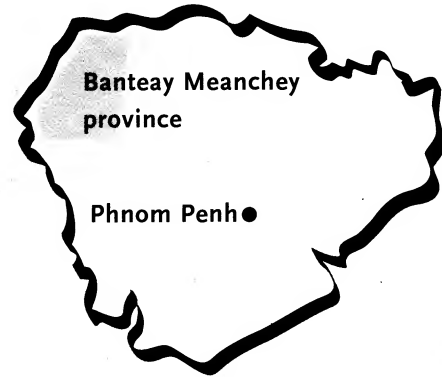
START DATE February 1996

END DATE March 1999

TARGET POPULATION 1,028
health staff and 74 traditional birth
attendants directly, and 373,500
population indirectly

PARTNERS Provincial Health
Department and other NGO's

FINANCED BY ECHO



At Provincial level, HealthNet's support has enabled nearly 100 staff in 12 health centres undergo basic training. These numbers were made possible through the building of a dormitory at the Provincial Training Centre which has meant that those from the more remote areas are now able to attend.

With sexually-transmitted diseases spreading at an alarming rate, the need for training in up-to-date methods of treatment was clear. HealthNet organised a week-long course for 20 midwives and doctors at both provincial and district levels.

Further training was also provided to update the skills of seven laboratory technicians and, working with SILAKA, a Khmer NGO, in management, supervision and administration.

At district level, in Preah Net Preah HealthNet renovated the tuberculosis and obstetrics wards, built a district pharmacy serving the whole district and an operational district office. Here, the fact that the local population was making increased use of the health services was reflected in the fact that nearly a third of all births were attended by trained midwives.

This improvement also showed in Phnom Srok district, where outpatient figures increased significantly and the incidence of dengue haemorrhagic fever reduced. Almost half of all births were attended by midwives.

Technical and managerial support was provided to 33 health staff across the Thmar Pouk district. HealthNet midwives organised a successful campaign to increase birth spacing.

However, the number of actual births attended by midwives was low, at 14.9%. A health centre, built by HealthNet in Tapho village, was completed in June and 26 new traditional birth attendants trained in modern birth practices.

After three years in Banteay Meanchey, there are still areas of concern and HealthNet will shortly begin a comprehensive evaluation of the project.



Cambodia Svay Rieng

Developing basic health care for the rural population

Cambodia is slowly recovering from years of war and conflict. Today it struggles to cope with a poor infrastructure, low socio-economic development, under-developed health and education services and a lack of skilled and educated people. For the rural population, the situation is made even more dangerous by the ever-present threat of landmines.

The breakdown of a fragile coalition between the warring parties in 1997 brought political instability and occasional fighting in western Cambodia, pushing new refugees across the border into Thailand. With the death of Pol Pot, the former leader of the Khmer Rouge, and the formation of another coalition government following the general elections, the political situation had stabilised again by the end of the year. There appears to be a real commitment to working towards democracy and reconciliation.

The government health services and the health of the population as a whole are still suffering the effects of the civil war. Infant and maternal mortality rates are among the highest

in the world. Most people do not have access to basic health services and rely instead on self-medication, traditional and private practitioners. This is serious in a country where common diseases such as malaria, tuberculosis, diarrhoea and respiratory illnesses are widespread and severe, and the situation is made more alarming by the recent rapid spread of sexually-transmitted diseases including AIDS.

In the light of this, 1996 saw the Ministry of Health start a major reform of the public health services. In Svay Rieng province, the provincial health department is working with HealthNet and UNICEF in a real effort to implement these reforms. By the end of 1998, many of the health centres

PROJECT TITLE Institutionalising mother and child health care in Svay Rieng Province, Cambodia

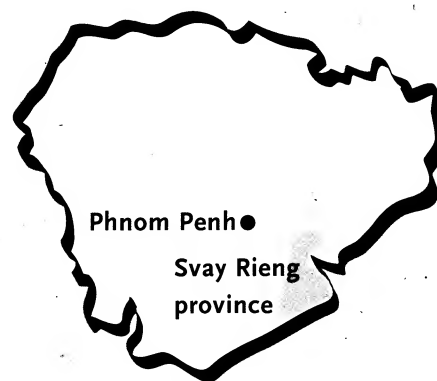
LOCATION Svay Rieng Province, Cambodia

START DATE January 1994

TARGET POPULATION 470,000

PARTNERS Provincial health department, UNICEF

FINANCED BY DGIS, MSF, Holland, British Embassy, German Embassy, Canada Fund



planned for are now operational. It is an important step but, with the health services clearly in a state of transition with both old and new systems co-existing, more work needs to be done.

During 1998 HealthNet continued to build on its previous achievements, developing services at health centre level and emphasising the provision of good quality health care for mothers and their children. The focus has been on directly involving the communities themselves in the provision of community-level health services. By doing so, HealthNet is aiming for the widest possible coverage, particularly for the poorest half of the population.

Nurses and midwives from 12 new health centres were given both clinical and management training to enable them to provide the best possible services to the rural population. Seven new health centres became operational and six more were about to open at the end of the year, bringing reliable health care to large sections of the population.

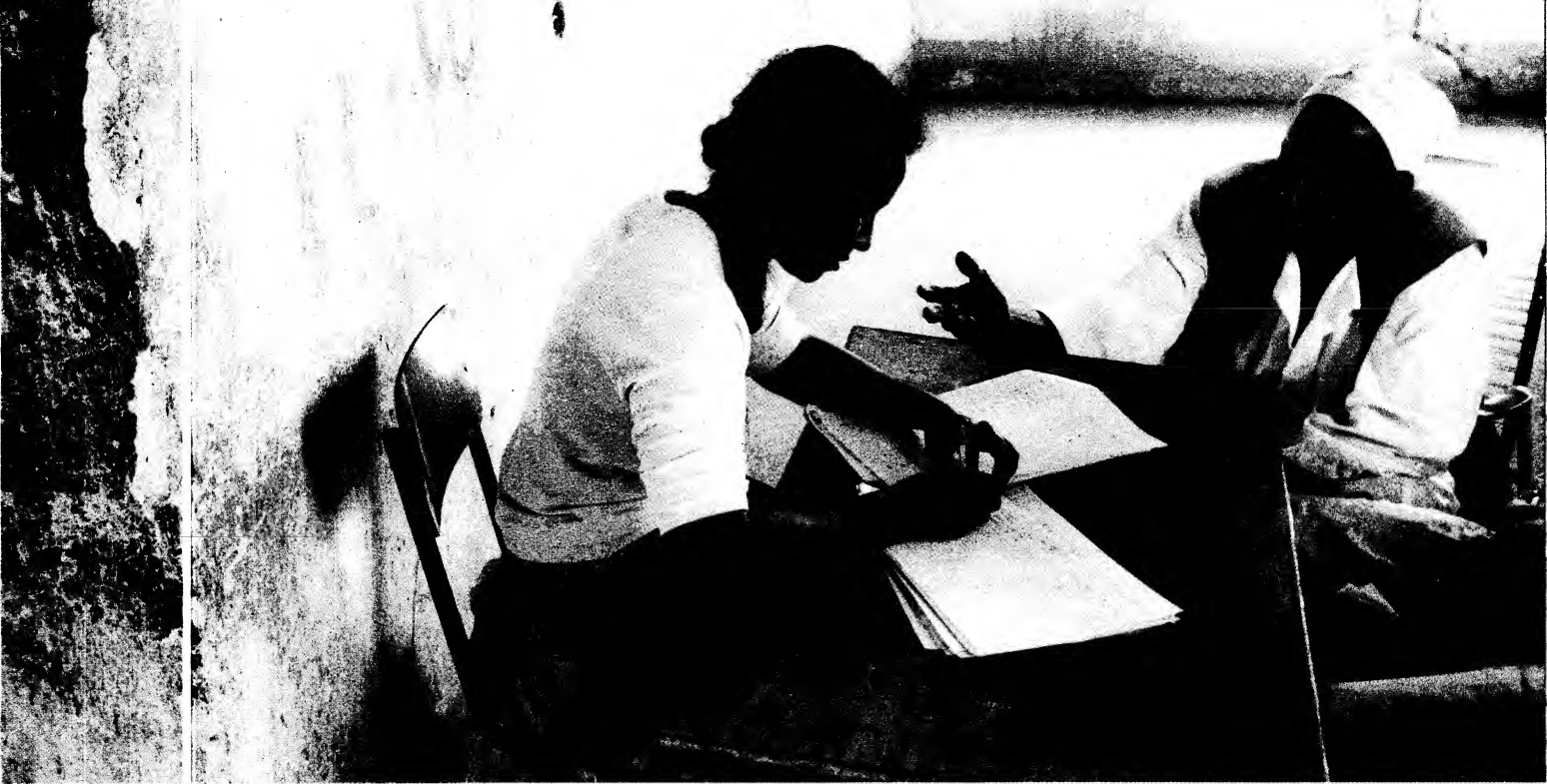
With no government budget to pay for basic running costs, a co-financing system has been established at each new health centre. Each one also now has a community co-management committee whose members have been trained by HealthNet to help them be as effective and proactive as possible.

Also at community level, 147 traditional birth attendants were trained to enable them to provide a safe and skilled service to women in labour. A further programme was started to build

effective working relationships with other health practitioners at village level which led to several workshops attended by traditional healers and private practitioners.

HealthNet continued its support to the Mother and Child Health (MCH) activities in the province. The MCH advisor trained staff from the obstetric ward of the provincial and referral hospital. As a result, emergency obstetric care and care for new-borns have both shown a marked improvement. At the same time, regular supervision and training for health centre midwives has meant that the ante-natal and family coverage rates achieved last year have been maintained.

1998 was a difficult year with elections, insecurity and a lack of budgets which adversely affected the health services. However, with a new government now in place and developments looking positive, 1999 may well see the coverage of services improve again. HealthNet will continue to work in Svay Rieng province for another two years focussing specifically on capacity-building in management, health centre development and community-based approaches.



Ethiopia

Training local NGOs to meet local needs

In May 1991, the 17-year Mengistu regime collapsed and the Ethiopian Peoples Revolutionary Democratic Front marched into Addis Ababa. The transitional government then installed was replaced in 1995 by a democratically elected government. Today, the Ethiopian Ministry of Health, along with the entire country, is being restructured and cannot yet provide adequate health care services to the population.

In this situation, both access to and the standard of medical care can be markedly improved if local experts and the communities themselves are involved. In the poor suburban areas of Addis Ababa, people are increasingly finding themselves with insufficient land to meet their needs and without any hope of finding alternative employment. It is here that local NGOs can play a key role and some have already begun projects to help those in greatest need.

Although Ethiopia's health care policy aims to provide similar standards of care to both urban and rural populations, most health care planning has taken place from the centre out. In reality this means that central demands are met first, regional demands second and those at the furthest edges come a poor third. As a result, the government-run health units in the

furthest reaches of the country are grossly under-funded and the population they exist to serve has little faith in them. Not surprisingly, morbidity and mortality rates are high.

Local NGOs have started projects to improve the quality of health services firmly based on the active involvement and participation of the communities.

One such NGO, Health Aid Ethiopia/Integrated Community Development (HAE/ICD), has been working in Akaki-Kaliti since 1995. Using a small health clinic as a base, it provides central health care and outreach services to the community.

Initially supported by MSF, the project was handed over to HealthNet in May 1997. The aim is to provide the organisation as a whole and individual staff with the skills, expertise and

PROJECT TITLE Co-operation
HealthNet International - Health Aid
Ethiopia/Integrated Community

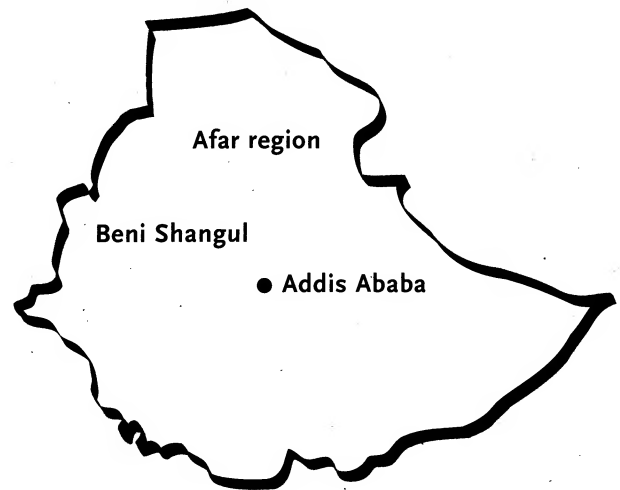
LOCATION Akaki-Kaliti area (zone
6 or region 14, Addis Abeba)

START DATE May 1997

TARGET POPULATION Indirectly
115,000 people and directly the
24 staff of HAE/ICD

PARTNERS Health Aid
Ethiopia/Integrated Community
Development

FINANCED BY Medecins sans
Frontieres-Holland



resources to be able to offer an efficient and locally relevant health care service with which the communities themselves are actively involved.

As such, HealthNet has provided specific training to key HAE/ICD staff on planning, implementing and managing health services, establishing outreach services and involving the community in health plans and activities. Equally important, administrative training in effective organisation management and establishing a competent and operational financial system was also provided.

In addition, those staff responsible for providing the outreach services were trained in the effective supervision and set up of community-based primary health care. HealthNet also provided support to HAE/ICD's 1998 national polio vaccination campaign. HealthNet International provided financial support to HAE/ICD for payment of local staff salaries, overhead costs, drugs & medical supplies, and fuel & maintenance for their vehicles.

Successful strengthening of local capacity depends on many aspects. Although, in the short term, HAE/ICD's activities had a positive impact on the health status of the target group, it was decided not to continue to support the NGO after the end of the project period, 31 December 1998. The NGO suffered from continued serious internal difficulties at managerial level. This prevented HealthNet International from accomplishing a sustainable improvement of the capacity of HAE/ICD - and enabled HealthNet to learn lessons in balancing management

and technical capacity of local partners.

In the first half of 1999 HealthNet International will start to improve the mother and child health services in Beni Shangul region, an extremely underserved and marginalised area in Western Ethiopia. HealthNet International will be the first international NGO to operate a health care project in this area. In addition to this, following an evaluation of the Afar Pastoral Development Project by the European Union, HealthNet International received a request from the Afar regional authorities to follow up the previous activities in the area. Discussions with the region about a renewed commitment are currently on-going.



Georgia

Supporting health sector reform

Georgia has been beset by serious economic decline since gaining independence in April 1991. It was a situation that was further worsened by major military conflicts in South Ossetia and Abkhazia which left some 280,000 people displaced. In May 1998, a further 40,000 people from Abkhazia fled the region.

Since 1995, however, the security and economic situations have generally stabilised and Georgia is now clearly in its 'second phase' of economic reform. Much still needs to be done, however, particularly in the areas of structural, institutional and legislative reform if the country is to be able to sustain this growth and fight the ever-present poverty of its people.

When it was part of the Soviet Union, Georgia's health care system was controlled from the centre. After independence, therefore, the country simply did not have the resources to maintain the delivery of free care and the health system failed. In 1995 in collaboration with the World Bank, Georgia began a series of well-intentioned health care reforms with the aim of decentralising the management. In practice, however, consistent funding shortfalls have hampered these reforms. Directors and other health professionals are being swamped by new rules and regulations which are often unclear and they lack the skills in modern management processes to implement

the new ways of doing things. The result is deteriorating facilities and services, a loss of public confidence and an overall decline in public health.

Particularly worrying is the increasing spread of infectious diseases, especially sexually transmitted diseases. Under Soviet rule, HIV/AIDS was deemed a problem outside the Communist sphere and any medical or public health risks to society were consistently denied. The legacy of this blinkered approach is that awareness and knowledge about HIV transmission and risk behaviours is almost non-existent, even among the health professionals.

In the autonomous republic of Achara in the south-west of Georgia both the health and political reforms have had little impact. Here, HealthNet continued its project managing and developing the Kobuleti Dispensary for Vulnerable People. This serves the most vulnerable 10% of the population: pensioners without support, displaced people and the poorest families. The

PROJECT TITLE Health care development project, The Republic of Georgia

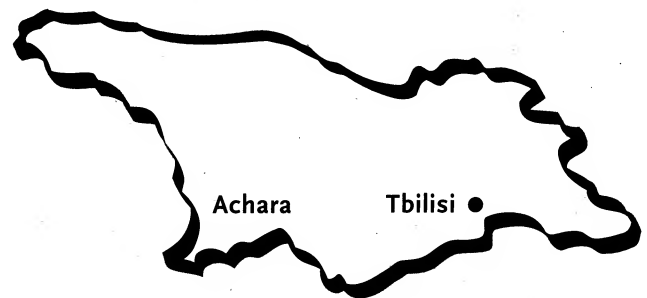
LOCATION Tbilisi and Achara

START DATE April 1997

TARGET POPULATION Internally displaced, risk groups for HIV/AIDS and vulnerable populations

PARTNERS Regional Health Authority, Georgian AIDS & Clinical Immunology Research Centre

FINANCED BY MSF Holland



screening system originally implemented by MSF to identify those most in need was further developed and promoted and its administration successfully handed over to the Kobuleti Social Affairs Department. In April 1998, a contract was signed with the Acharan government to set up a cost-sharing scheme to cover the Dispensary running costs. Four months later, HealthNet again handed over all these initiatives to the Ministry of Health.

Along with other former Soviet countries, Georgia is at high risk of witnessing the rapid spread of HIV/AIDS unless urgent measures are taken. Through its safe blood supply project, taken over from MSF in 1997, HealthNet is the lead agency working with the UNAIDS Theme group in Georgia and has developed links with other institutions working in HIV/AIDS prevention.

HealthNet's pilot project in HIV/AIDS prevention has been targeted at the capital, Tbilisi, where about a third of the overall population live. The year has seen HealthNet continue to promote an increased understanding of HIV/AIDS and STDs and to provide the Georgian AIDS & Clinical Immunology Research Center with technical and financial support for its public education and mobilisation program.

Sponsored by UNAIDS, HealthNet joined in a rapid assessment mission with a consultant from the Trimbos Institute at The Netherlands Institute of Mental Health and Addiction. The results provided the basis for a project proposal on the prevention of HIV/AIDS and related infectious diseases among

prisoners, one of the highest risk groups in the country.

Following a request from the Georgian Ministry of Health, HealthNet developed a series of management training courses for hospital and polyclinic directors and managers. Working in partnership with the National Health Management Training Centre, a consultant spent six months assessing the current needs. Their report identifies both the real need for such training and, equally importantly, a willingness on the part of the directors and managers to invest their time.

By the end of 1998, HealthNet was still trying to secure sufficient funding for both the HIV/AIDS and training projects.



Mozambique

Bringing health care to rural communities

Mozambique has now enjoyed seven years of political stability during which the democratic processes have been strengthened. Today the country is moving increasingly from rehabilitation to long-term development. As a result, it is one of just a handful of countries selected by the Dutch government to continue receiving Dutch foreign assistance. In Nampula Province, one of the most heavily populated and poorest in the country, this assistance plays a key role in building up and strengthening vital private and public institutions.

In the health sector, the emphasis clearly needs to be on supporting improvements to the government health services and encouraging better health through prevention by involving the communities themselves. The region has very high maternal and child mortality rates and poor environmental health conditions mean that the population is susceptible to outbreaks of infectious diseases. The health system itself operates within several constraints. There are few health workers with medium or advanced level training which limits both the quality of care and its availability in rural areas. At the same time, problems in drug supply lead to extended periods of drug shortages and the physical infrastructure of the health system is inadequate and

deteriorating. The District Health Departments themselves have limited resources which means that rural communities are often not reached. As a result, there is low vaccination coverage and little support to Community Health Workers.

Based in the Southern region of Nampula Province, HealthNet is working to improve the health of, and health service provision for, the population, particularly for the women and children. Co-ordinated by a Steering Committee made up of the four District Health Directors, a representative of the Provincial Health Department and the HealthNet Programme Manager, the aim is to improve the quality and delivery of maternal and child health (MCH) services and increase

PROJECT TITLE Okhaliha Ekumi
Project ('Supporting Health' in the
Macua language)

LOCATION Nampula Province

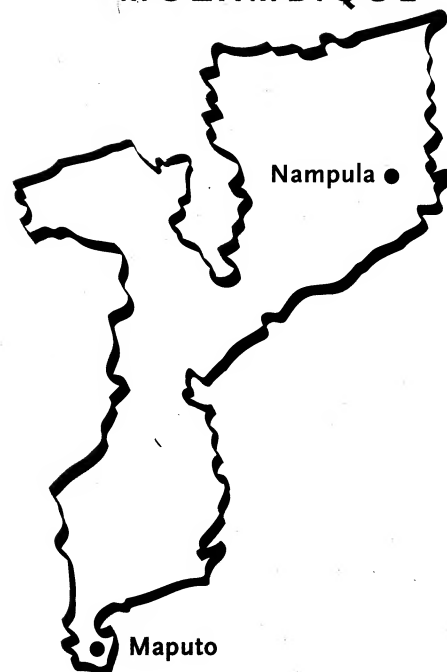
START DATE July 1998

END DATE June 2001

TARGET POPULATION Local
population in four districts –
c. 900,000

FINANCED BY Royal Netherlands
Embassy, Maputo, ICCO

MOZAMBIQUE



vaccination coverage. Rehabilitating specific health infrastructures and improving the drug supply system are also key priorities of the project.

A week long technical seminar for all MCH nurses and midwives in the region was particularly important. Concentrating on pre-natal care, delivery and referral procedures, the seminar was a step forward in developing effective strategies for combating the very high rates of maternal mortality. Field supervision following the seminar and HealthNet's continued support of the annual refresher courses for traditional midwives ensured that a great deal continued to be done to improve the care of mothers in childbirth.

Up-to date treatment techniques for respiratory infections, diarrhoeal diseases and malaria were provided for health staff and community volunteers in a series of three-day courses held in each district. Volunteers from three of the districts were also trained in cholera prevention and education techniques. During the cholera epidemic in 1998, these volunteers were also supported in their efforts to bring these to individual families in a door-to-door campaign.

During the war in Mozambique the health sector was targeted by rebels as a way to undermine social stability. This caused a breach in trust between parts of the population and the health services. The programme is working with the health staff to bridge this gap, and re-establish the basic trust necessary to rebuild society.

For the Polio Eradication Campaign, HealthNet provided training for health workers and community volunteers as well as transportation and other related costs for the mobile vaccination teams. Further transportation support was also provided for the other regular vaccination activities through the year. In the coming year, HealthNet is aiming to provide transportation and the necessary 'cold chain' equipment for those vaccinations which need to be maintained at a constant temperature.

Towards the end of 1998, attention turned to the real need to rehabilitate the health service buildings. By the end of the year, work on four health posts, two residences, a pharmacy waiting area and latrines and bath houses had either been completed or was underway.

This work will continue in the coming year. Other plans include providing 'training of trainer' courses in mother and child health, vaccination and supply systems as well as ensuring stronger technical support to planning, management and supervision.



Pakistan/Afghanistan

New weapons against an old enemy

While the strict rule of the Taliban has brought some stability to much of Afghanistan, the civil war continues in the north and centre diverting government energies away from rebuilding even a basic infrastructure. The years of conflict have left the population living in dreadful conditions with little in the form of social services or health care. For the 1.5 million Afghans still living in refugee camps in Pakistan, the conditions still fall a long way short of where they need to be to entice them home.

The Taliban themselves regard non-governmental organisations and UN agencies working in the country with suspicion. In 1998 this was characterised by increasing tension between the Taliban authorities and the international organisations, which culminated in the expulsion of the latter from the capital of Kabul in July. The UN agencies also curtailed their activities in the wake of the US missile attack and the retaliatory killing that followed.

As the poorest country in Asia, Afghanistan's health services are woefully deficient. The improvement in security in the past few years has led to increased provision of health care from UN and NGO agencies under the nominal control of the Taliban-led Ministry of Public Health. Malaria remains a real threat, having taken its grip during the war as the health system broke down, control measures were disrupted and large

numbers of people with no natural immunity moved en masse. Having taken over the malaria control programme from MSF in 1993, HealthNet has introduced a series of successful preventative techniques. Working with other NGOs, the Ministry of Public Health, UNHCR and WHO, HealthNet staff both co-ordinate and improve all malaria control activities in both Afghanistan and among the refugees in Pakistan. The programme, which was extended in 1998 to cover both Kandahar and the Southern Region of Afghanistan, has two core approaches.

The first is aimed at promoting sustainable methods of personal protection and thus to control the spread of the disease. With livestock and domestic animals one of the prime sources of the spread of malaria, it was clear that treating them with insecticide would dramatically improve prevention

PROJECT TITLE Prevention and control of malaria in Afghanistan and in the refugee camps in Pakistan

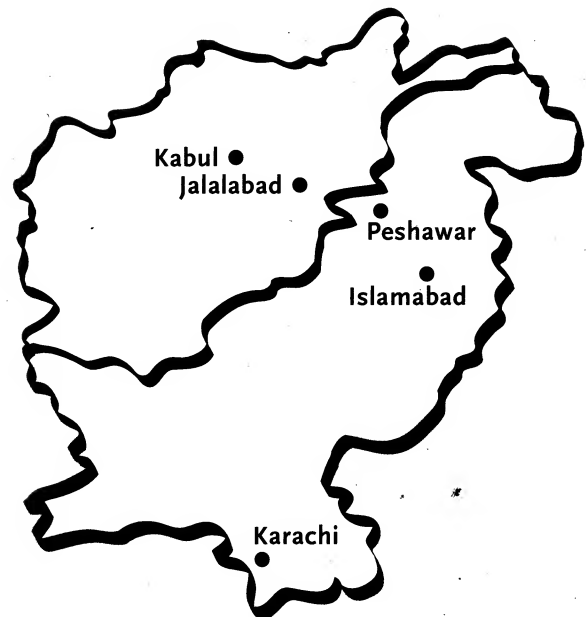
LOCATION Eastern and Southern Regions of Afghanistan (centred on the cities of Jalalabad and Kandahar respectively) and North-West Frontier, Punjab and Balochistan Provinces of Pakistan

START DATE October 1993

TARGET POPULATION About 1.5 million Afghan refugees in Pakistan and local populations of Eastern and Southern Afghanistan

PARTNERS Ministry of Public Health, WHO, WFP, Government of Pakistan's Afghan Refugee Organisation, local and international NGOs

FINANCED BY European Union, UNHCR, WHO



efforts. When HealthNet first introduced this approach in 1997, it proved markedly more successful and cost-effective than the alternative method of house spraying. For example, in the badly-affected Adizai camp, the number of cases fell from 1,032 cases in 1996 to just 44 in 1997 at a cost of just \$125.

Ensuring the supply and use of impregnated bed-nets has also proved an effective defence. Since 1993, 230,000 of these have been sold throughout seven Eastern Afghanistan provinces. Today they are protecting some 800,000 people. To remain effective, the nets must be retreated with insecticide each year and several distribution methods have been tested to ensure the most effective way of achieving this.

The cost of the bed-nets themselves may be beyond the means of some people. Up to 50% protection, however, is possible through treating chaddors (Islamic head and body wraps) and outer bed sheets with insecticide. Although this is a slightly less effective option, it is cheaper and gives a reasonable level of protection.

By using a combination of all three methods within communities, HealthNet is ensuring that everyone has some form of protection against malaria.

The second core approach of the programme focuses on training. Courses for malaria microscopists and doctors are provided for staff of partner organisations. HealthNet also maintains malaria reference centres in both Pakistan and Afghanistan which help to ensure the quality control of

diagnostic work in each clinic. Through these activities, the programme is developing into a regional resources center for the prevention and control of malaria.



Peru

Coping with the medical and social effects of war

After almost 14 years of civil war, Peru today is edging towards economic and political stability. Inflation has reduced, foreign investment has increased and the government has initiated reconstruction schemes in the rural areas, including investments in health and education. However, 46% of the population still lives below the poverty line and public services are far from adequate. With the destructive effects of El Nino and the Asian crisis, Peru is facing a period of recession affecting particularly the small and medium-sized businesses. Both production and employment will decrease.

Ayacucho is one of the poorest departments of Peru and an area of high unemployment. It bore the brunt of the political violence of the 1980s and early 1990s. Many of those who stayed are traumatised; many others migrated to the coastal areas and Lima. Alcoholism and family violence are prevalent and the health of mothers and children is poor with high rates of infant and maternal mortality.

While the Ministry of Health has begun a basic health care programme in the rural areas, the staff are concentrating on curative rather than preventive services. Problems such as alcoholism and violence, regarded in Peru as mental health

problems, are recognised but ignored.

When HealthNet took over the Mother and Child Health Programme from MSF in January 1998, the first step was to assess the immediate needs of the local population. Alcoholism, family violence, and mother and child health were clearly identified priorities. Using the experience gained from MSF, the team developed a plan which emphasised the active participation of all those involved. As a result, relations with government health personnel were reinforced, teachers were met with and motivated, and a group of active village men and women selected to work with the team. Training of each of these groups was essential if they were

PERU

PROJECT TITLE The community health and social rehabilitation in the provinces of Fajardo and Vilcas Huaman

LOCATION Department Ayacucho, Provinces Fajardo and Vilcas Huaman (a total of 13 villages)

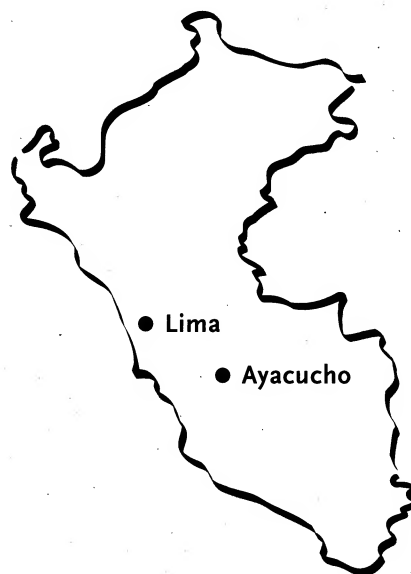
START DATE January 1998

END DATE December 1999

TARGET POPULATION 40,381 people in the rural areas; health personnel and teachers; community members (men, women, adolescents and authorities)

PARTNERS Ministry of Health, Ministry of Education and co-operating authorities. Contacts have been established with local organisations such as KALLPA, Chirapagh, Manuela Ramon and Vecinos Peru

FINANCED BY MSF Holland



then to go on and educate their peers. In May 1998, a series of training workshops were developed and tested and specially designed appropriate education materials and information sheets prepared.

The implementation of these interventions at the community level got underway in Fajardo and Vilcas Huaman. Using participatory exercises, those attending were able to explore and understand alcoholism and family violence, acute respiratory infections and diarrhoea. Later in the year, two further workshops, on Participatory Methodologies and Leadership, were also introduced.

Each workshop was followed by active sessions where the trainees themselves prepared to teach others what they had learned. Various methods such as theatre and role playing, puppets and drawings are used to spread the message to others in their village. It is planned to include video recordings of the role playing in the near future. By working with the population in the design and implementation of these community interventions, social rehabilitation processes are strengthened.

At the request of donors, HealthNet International developed a project proposal on sexual and reproductive health of adolescents, which is expected to begin in the latter part of 1999. This year will also see the implementation, in conjunction with KALLPA, of a school health programme alongside campaigns on acute respiratory infections and family violence.



Romania

Broadening the horizons of medical specialists

Since the Revolution in 1989, Romania has edged towards democracy and economic reform, particularly following the election of a more progressive government in 1996. However, the vast majority of the population continues to live with low incomes or unemployment while struggling to cope with the demands of a modernising society. The country is not yet back to its pre-revolution production or economic levels.

In 1998, preparations were made for major reforms in the health sector. These will directly affect the positions and professional requirements of both medical specialists and family practitioners. While it will be a major step forward in the long term, the short term effect will be to reduce the performance of an already under-resourced system.

Measures to improve the efficiency and quality of the health service are badly needed. Decentralisation and democratisation in the health sector are essential, as is the assistance of a number of Dutch organisations in the development of Family Medicine.

Health Net's key aim is to give Romanian specialists, who currently tend to work in isolation, the opportunity

to experience working in a modern health system, to encourage them both to perform better and to become advocates for change.

Since 1990, between 13 and 15 specialists each year have spent two months working alongside a Dutch equivalent in a Dutch hospital. They are carefully selected against specific criteria such as motivation, age, professional interest and language skills. Most fellowship places are found in the randstad, with the university hospitals of Utrecht and Amsterdam taking the largest number of specialists.

1998 saw 14 such specialists undertaking these fellowships. While there are some techniques which they will not be able to use in Romania through lack of equipment or organisation,

PROJECT TITLE Support to Romanian specialists

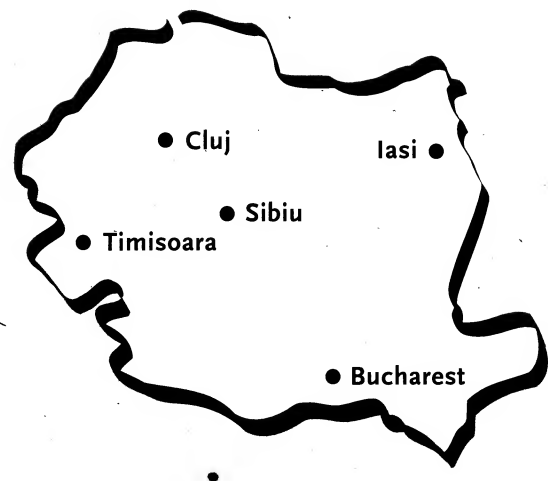
PROJECT FEATURES Started in 1990 by Médecins Sans Frontières (MSF) Holland, the project was taken over by Health Net in 1996. Current planning of activities extends well beyond 2002.

START DATE September 1996

TARGET POPULATION Medical specialists from throughout Romania but mainly from Transylvania. Indirectly, the project aims to support the patients in hospitals.

PARTNERS In Romania: Duromef, a local NGO
In the Netherlands: Dutch medical specialists who are prepared to receive a colleague from Romania.

FINANCED BY MSF Holland



the vast majority learn many relevant skills. But their visit does more than teach them new skills: it gives them the chance to see for themselves how a modern health system works and how the staff within it interact. In Romania, for example, specialists do not tend to discuss work with the nursing staff and to see the real benefits of this in action helps them to reconsider their own way of working. Most are also completely new to the use of diagnostic or treatment protocols or guidelines.

In 1993, those Romanian specialists who had completed the fellowship founded an association, Duromef, which today has 98 members. With the support of HealthNet, the association helps with the selection of new specialists, organises hospital management workshops and holds an annual meeting.

In anticipation of the planned end of the project in 1999, a symposium was held in June at the University Hospital of Utrecht with speakers from both Romania and the Netherlands. Here it was recommended that, given the huge health needs of the country, Health Net should continue to work in Romania with the focus moving towards the relationship and collaboration between medical specialists and family practitioners and others working in the front line of health care.

By the end of the year, Duromef had submitted 15 project proposals. HealthNet will submit those that qualify for its support to various donors for funding and it is hoped that several will be operational by the end of 1999. Further

funding is also being sought to continue the fellowship programme itself.



Rwanda

Ensuring quality care for the victims of war

The impact of the civil war and 1994 genocide in Rwanda is still felt by those who survived and who are now trying to rebuild their lives. Any progress towards reconciliation and peace is hampered by the continued instability of the region, particularly the war in the Congo. The present government in Kigali remains under threat from the perpetrators of the genocide who have regrouped and now plague the borders. Such insecurity remains a major barrier to those wanting to return home and resume a normal life and limits the resources which the government can invest in providing social services which are badly needed, particularly as the country faces the huge task of resettling an estimated one million refugees.

The unstable situation has meant that basic health services remain in tatters. The chaos of 1994 saw facilities looted and destroyed, skilled staff either killed or forced to flee the country and basic management and supervisory systems severely compromised. Those health facilities and services that are functioning are doing so at greatly reduced levels. Specialised services, such as those for disabled people, are almost non-existent in many areas; services which are sorely needed in the light of the severe mental and physical injuries suffered by many.

Any such services tend to be based in the capital Kigali. As a result, many of those living in the rural areas, where the most common problems can be avoided by basic preventive measures, have no access and risk developing permanent disabilities.

HealthNet has worked closely with the Ministry of Health and several local organisations to develop appropriate rehabilitation services for the disabled and for those at risk of developing permanent disabilities from previous injuries.

PROJECT TITLE *Towards better care for war victims and handicapped in Rwanda through the development of rehabilitation services at peripheral level*

LOCATION Kigali and 11 health districts

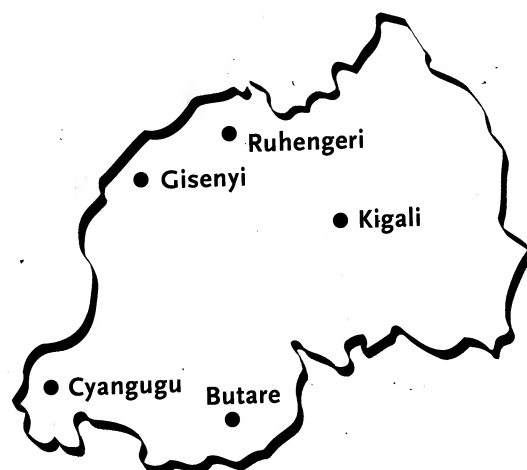
START DATE August 1995

END DATE November 1998

TARGET POPULATION Disabled and vulnerable groups

PARTNERS Ministry of Health, local and international NGOs

FINANCED BY MSF Holland, European Union



The strategy was threefold: the provision of relevant training and resources and enabling policy development in the field of community-based rehabilitation.

During 1998, 11 doctors and 22 nurses attached to the 11 regional hospitals have completed training programmes aimed at giving them the knowledge and skills to provide much needed care to those suffering from complicated orthopaedic and trauma injuries. HealthNet also continued to support the orthopaedic department of the King Faisal Hospital in Kigali, which provided the main curative services during the genocide, until March 1998 when the hospital went into private hands.

HealthNet worked closely with several of the organisations and institutions active in the field of rehabilitation in Rwanda. Just one example was the provision of a surgeon and anaesthetist to the Gatagara Rehabilitation Centre twice a month to undertake corrective surgery for disabled children. HealthNet also sponsored monthly meetings at the University Hospital of Butare providing consultation and on-the-job training for health staff in dealing with complicated orthopaedic and trauma cases. Liaison with other organisations ranged from collaboration and information exchange to providing direct funding and technical support.

1998 also saw a significant contribution in the development of a multi-sectoral strategic plan for the rehabilitation of the disabled following a major workshop which brought together the key stakeholders. The final plan will help organisations to

set priorities and plan their activities in a co-ordinated way.

Although the project ended in November 1998, HealthNet was asked by the Ministry of Health to assess the needs in the nursing sector. As a result, HealthNet has produced a project proposal focusing on the development of the nursing sector at both national and peripheral levels, and is aiming to explore the needs in the area of mental health.

Rwanda has a long way to go to establish peace and reconciliation. It is a process which continues to need considerable time and resources before real and positive results are achieved.



Southern Sudan

Fighting river blindness in Southern Sudan

1998 began with a major military offensive which was followed by the worst drought and famine seen in the region for over a decade with some 2.6 million Sudanese people affected. The international community of non-governmental organisations working in the south described the situation as having reached 'unimaginable and extraordinary levels'.

Some 13 million people in Africa are infected with 'river blindness', or onchocerciasis. The disease leaves its victims either blind or severely visually impaired and thus wreaks social and economic havoc among rural communities. In the 1970s the World Health Organisation launched an intensive campaign to eliminate the disease in West Africa and four years ago extended this to a further 19 countries throughout inter-tropical Africa.

In war-torn Southern Sudan, initial studies of the prevalence of the disease, which requires annual treatment for at least ten years, showed that treatment was required in 60% of communities. It was clear that an organised national distribution programme of the treatment drug, ivermectin, was essential and in 1996 HealthNet became the co-ordinating agency for all the work being undertaken by

non-governmental organisations.

In this vast area of country characterised by harsh terrain, bad roads and little infrastructure, there is a severe shortage of trained health workers and facilities. Finding sufficient staff to operate a national ivermectin distribution programme, therefore, is a daunting task.

The manufacturers of the treatment drug ivermectin (Mectizan®), Merck, donate the drug to any country with endemic onchocerciasis for as long as necessary with applications to begin a programme being filed with the Mectizan® Donation Program in the United States. As the co-ordinating agency, HealthNet is responsible for filing the applications and reporting back to strict requirements.

One of the most reliable control programs, adopted and

SOUTHERN SUDAN

PROJECT TITLE Southern Sudan Onchocerciasis Control Programme

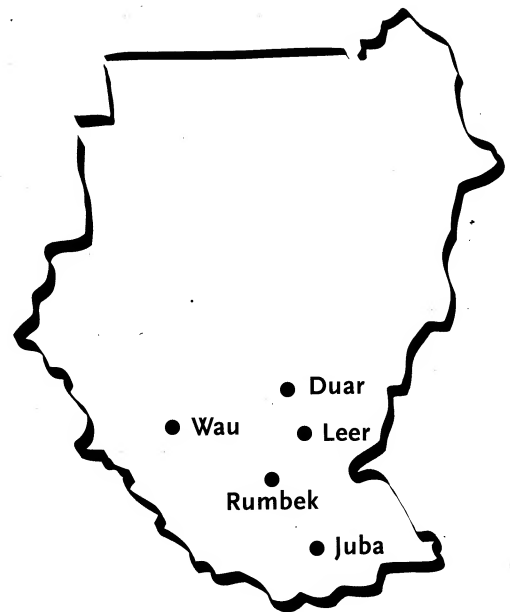
LOCATION Southern Sudan: Bahr el Ghazal, Lakes, Eastern and Western Equatoria, Jonglei, Upper Nile

START DATE March 1996

TARGET POPULATION 800,000 residents, internally displaced, returnees (80% of the cases in Sudan)

PARTNERS 33 international and local NGOs Southern Sudan Relief and Rehabilitation Association African Programme for Onchocerciasis Control UNICEF/Operation Lifeline Sudan The Mectizan Donation Programme

FINANCED BY VISIO APOC



supported by WHO's African Programme for Onchocerciasis Control (APOC), is to use locally trained volunteers as distributors in a mass distribution of the drug to entire communities. This is known as 'community directed treatment with ivermectin' or CDTI. The approach relies on the commitment of health workers and communities to mobilise sufficient resources once a year to ensure the treatment is carried out. As such, it makes the communities themselves responsible for the efforts to control the disease.

HealthNet's two key objectives for 1998 were to increase the number and coverage of ivermectin treatments and to begin the training of local health workers and community selected distributors. With HealthNet's assistance and in partnership with NGOs, APOC and the local communities themselves, 12 local people attended a multi-country APOC workshop in Nairobi, 37 attended a CDTI 'trainer of trainers' workshop, 95 health workers and community leaders were trained in CDTI and 114 volunteers selected by their communities were trained as community directed distributors of ivermectin.

Despite 1998's devastating famine, the presence and severity of onchocerciasis was evaluated in a further 65 communities. 120,000 people were treated, a 41% increase on 1997.

1998 was the first year for the CDTI strategy and the results so far are promising. This is particularly the case in the willingness of the communities to claim ownership of the initiative by selecting their most trusted members to be trained as ivermectin distributors. The effect of this communal

activity may exceed the aim of eradicating onchocerciasis alone. HealthNet remains committed to working alongside APOC to achieve a sustainable community-directed approach to this extra burden in war-torn Southern Sudan.

Staff and Relations

Board of Administrators

Chairman	P.K.H. Meyer Swantée <i>(until October)</i> Y. Baune <i>(from October)</i>
Vice-chairman	P.K.H. Meyer Swantée <i>(from October)</i>
Secretary	J. de Milliano
Treasurer	H.J. Meijman <i>(until September)</i> Ruud Keulen <i>(from September)</i>
Member	A.M.F. Winkler H.J. Meijman <i>(from September)</i>

Amsterdam Staff

Director	Egbert Sondorp <i>(until February)</i> Willem van de Put <i>(from October)</i>
Director ad interim	Vincent Faber <i>(from February until September)</i>
Senior Programme Manager	Vincent Faber Geert Leerink Jackie Lemlin

Project Management Assistant	Ineke Boersma Annelies Gieles Judith Zaal	Bosnia	Linda de Clercq Mira Dodig Lee Obomeghie Bart Smet
Financial Manager	Jeroen Mous		Bert Bosch
Management Accountant	Liliana Jauregui Bordones Arthur Zuidema	Cambodia	Jaime Calderon Mary Dunbar Fred Griffiths Debra Hartley
Bookkeeping/Administration	Els van Lindt Pieter Woldendorp		Joost Hoekstra Pratap Jayavanth Janath Rajakaruna Froukje Zwaga
Co-ordinator			Peter Driedijk Reingard Engert Susan Landfield Erik Schouten Nelleke Snijder-Hovestreydt
Rumania Programme	Gaby Oltean-Lungu <i>(Field staff stationed at HQ)</i>		Henk Bruyn Irene Goepp Geert Leerink Bob Matemera Linda Casey Naimeh Baidoun Jeanet van de Korput Willeke Kempkes
International Field Staff		Ethiopia	
Afghanistan/Pakistan	Sonia Bertrand	Georgia	
	Jonathan Crofts		
	Marleen Deerenberg		
	Tim Freeman	Kenya / South Sudan	
	Linus Harms		
	Marijke Koggel		
	Chandana Mendis		
	Isam Mirghani	Mozambique	
	Denis de Poerck	Peru	
	Ahmed abd el Rahman		
	Hugh Reburn	Rwanda	
	Mark Rowland		
	Alexandra Simon-Taha		
	Xandra Slavenburg		

External Consultants

Hein van Vliet
Geert Leerink
Christine Bousquet
Lena Choudary
Rosemarie de Loor
Geertruid Kortmann
Rolf Kleber
Carlo Mittendorf
Michiel Lekkerkerker
Joost Hoppenbrouwer

Bankers

ABN AMRO Bank NV
Leidseplein 25
Amsterdam

Auditors

KPMG Klynveld Accountants NV
Burg. Rijderslaan 10-20
Amstelveen

Stichting HealthNet International, Amsterdam
Financial statements
1998

Balance Sheet at 31 December 1998

(After Appropriation of the Balance of Income and Expenditure)

(In Dutch guilders)

	Note	December 31 1998	December 31 1997
Assets			
Fixed Assets	3	80,514	88,242
Receivables From Supporting Institutions	4	13,124,096	6,932,880
Other Receivables		183,036	140,409
Cash and Banks	5	2,798,469	2,502,089
		<u>16,186,115</u>	<u>9,663,620</u>

Liabilities

Loan from SF-Holland	6	315,000	360,000
Budgetary Commitments	7	14,252,403	8,440,273
Current Liabilities	8	769,014	226,426
		<u>15,336,417</u>	<u>9,026,699</u>
Total Assets Less Liabilities		<u><u>849,698</u></u>	<u><u>636,921</u></u>

Representing:

Funds

	9		
Unrestricted funds		455,427	299,378
Designated funds		379,970	303,692
Restricted funds		14,301	33,851
		<u>849,698</u>	<u>636,921</u>

Statement of Income and Expenditure for the year ended 31 December 1998

(In Dutch guilders)

	Note	1998	1997
Income			
Project Grants		10,040,847	7,912,001
Consistencies	10	91,012	55,897
Donations from others		54,967	77,148
Interest		30,728	49,096
Other	11	205,514	150,439
		<u>10,423,068</u>	<u>8,244,581</u>

Expenses

Projects	12	9,125,300	7,548,024
Consistencies	10	128,552	76,404
Office	13	956,439	811,427
		<u>10,210,291</u>	<u>8,435,855</u>
Balance of Income and Expenditure		<u><u>212,777</u></u>	<u><u>-191,274</u></u>

Appropriation of the Deficit/Surplus 9

Unrestricted funds		148,323	165,811
Designated funds		84,004	-143,585
Restricted funds		-19,550	-213,500
		<u>212,777</u>	<u>-191,274</u>

Notes to the Financial Statements

1 General

The foundation STICHTING HEALTHNET INTERNATIONAL was incorporated on October 26, 1992. The main objective of the foundation is to contribute to a sustained improvement of the health of vulnerable population groups in areas hit by crises by means of a development oriented approach, as soon as this becomes possible.

2 Accounting policies

The following accounting policies have been applied consistently in dealing with items which are considered material in relation to the financial statements.

Foreign currencies

Transactions in foreign currencies are recorded using the rate of exchange at the date of the transaction. Monetary assets and liabilities denominated in foreign currencies are translated using the rate of exchange at the balance sheet date and gains or losses on transactions are included in the profit and loss account.

Fixed assets and depreciation

Tangible fixed assets are stated at the historical costs less depreciation. Depreciation is provided at the following rates:

Office furniture	14.3% per annum
Office equipment	20.0% per annum
Office reconstruction	33.3% per annum
Computer hardware and software	33.3% per annum

Other assets and liabilities

All other assets and liabilities are stated at nominal value

Income and expenditure

Income and expenditure are recorded in the period to which they relate.

Project grants

Pledged project grants and the resulting budgetary commitments are stated in the balance sheet on the date of the pledge. Grants are recognised as income in the statement of income and expenditure in proportion to the progress of the project.

Costs

The expenses of the Amsterdam office staff directly attributable to projects, are stated as such under the corresponding heading.

3 Fixed Assets (In Dutch guilders)

	Furniture	Reconstruction	Equipment	Computers	Total
Cost					
Balance at 1 January 1998	57,151	19,948	23,847	80,986	181,932
Additions	5,557	-	-	22,928	28,485
Disposals	-	-	-1,409	-22,135	-23,544
Balance at 31 December 1998	<u>62,708</u>	<u>19,948</u>	<u>22,438</u>	<u>81,779</u>	<u>186,873</u>
Depreciation					
Balance at 1 January 1998	15,426	4,987	19,785	53,492	93,690
Charge for year	9,031	6,650	1,412	19,120	36,213
Disposals	-	-	-1,409	-22,135	-23,544
Balance at 31 December 1998	<u>24,457</u>	<u>11,637</u>	<u>19,788</u>	<u>50,477</u>	<u>106,359</u>
Net book value					
At 31 December 1998	<u>38,251</u>	<u>8,311</u>	<u>2,650</u>	<u>31,302</u>	<u>80,514</u>

4 Receivables From Supporting Institutions (In Dutch guilders)

	1998	1997
Balance at 1 January	6,932,880	6,912,127
Add: Pledged project grants	16,605,391	8,286,147
Less: Received project grants	-9,676,827	-7,908,984
Non-applied project grants	-690,349	-427,719
Exchange differences	-46,999	71,309
Balance at 31 December	<u>13,124,096</u>	<u>6,932,880</u>

Notes to the Financial Statements

4 Receivables From Supporting Institutions (continued) (In Dutch guilders)

Project grants have been received from:

	1998	1997
Asian Development Bank	448,218	-
Commission of the European Union	3,526,278	2,806,594
Dutch Government (NEDA)	2,034,976	433,917
ICCO	165,710	180,928
MSF-Holland	2,920,008	3,448,036
Norwegian Church Aid	-	107,761
PACT (USA)	-	167,737
Stichting VISIO	247,160	529,549
United Nations organisations	298,523	159,249
Others	35,954	75,213
	<u>9,676,827</u>	<u>7,908,984</u>

5 Cash and Banks (In Dutch guilders)

	1998	1997
Cash and banks Amsterdam	1,833,737	1,731,025
Cash and banks in project countries	964,732	771,064
	<u>2,798,469</u>	<u>2,502,089</u>

6 Loan MSF-Holland

In the first three years HealthNet has been supported financially by MSF-Holland in the form of a subordinated loan of Fl. 450,000. The loan is free of interest with a repayment schedule which has started in 1996 at Fl. 45,000 per year over a period of ten years.

7 Budgetary Commitments (In Dutch guilders)

	1998	1997
Balance at 1 January	8,440,273	8,419,446
Add: Pledged project grants	16,605,391	8,286,147
Less: Applied project grants	-10,040,847	-7,912,001
Non-applied project grants	-690,349	-427,719
Exchange differences	-62,065	74,400
Balance at 31 December	<u>14,252,403</u>	<u>8,440,273</u>

Overview of budgetary commitments per country:

Afghanistan	2,638,861	4,108,811
Angola	-	146,815
Bosnia	1,643,108	-
Cambodia	4,424,905	502,915
Ethiopia	572,430	316,517
Georgia	122,187	515,697
Haiti	-	157,242
Mozambique	3,574,526	-
Pakistan	-	12,246
Peru	843,458	1,281,820
Romania	154,386	358,585
Rwanda	-	796,919
South Sudan	215,229	238,164
Uganda	-	4,542
Various	63,313	-
	<u>14,252,403</u>	<u>8,440,273</u>

8 Current liabilities (In Dutch guilders)

	1998	1997
Creditors	313,476	38,328
MSF-Holland	87,723	21,660
Other	367,815	166,438
	<u>769,014</u>	<u>226,426</u>

Notes to the Financial Statements

9 Funds (In Dutch guilders)

	Unrestricted	Designated	Restricted	Total
Balance at 1 January 1998	299,378	303,692	33,851	636,921
Appropriation of the deficit/surplus	148,323	84,004	-19,550	212,777
Add/(less): Inter fund transfers	7,726	-7,726	-	-
Balance at 31 December 1998	<u>455,427</u>	<u>379,970</u>	<u>14,301</u>	<u>849,698</u>

Unrestricted funds

The unrestricted funds consist of accumulated funds which may be used for purposes as approved by the directors.

Designated funds

The designated funds consist of the *fixed assets capital fund*, representing the net book value of the fixed assets of the foundation, and cost recovery funds related to the malaria control program in Pakistan and Afghanistan. This fund is increased by the income from sold mosquito nets and decreased by expenditures related to the replenishment of supplies. Although the sales price is below cost price, the surplus is caused by a free supply of nets by UNHCR and the European Commission (see also note 11).

Restricted funds

The restricted funds consist of not yet expended restricted donations.

10 Consultancies

Expenses under this heading mainly include feasibility studies and assessment missions, carried out for the identification of new activities. The expenses include direct salary costs in the amount of Fl. 8,500 (1997: Fl. 8,000) related to staff which are based at the Amsterdam office.

11 Other income

Other income represents the gross revenues from cost recovery schemes of which the largest concerns the sale of mosquito nets in Afghanistan. At the end of the year the net revenues - being gross sales minus project costs - are added to the designated funds.

12 Project expenses (In Dutch guilders)

	1998	1997
Expenses per country:		
Afghanistan	3,287,312	1,764,103
Angola	111,875	138,078
Bosnia	1,264,693	-
Cambodia	1,257,083	955,419
Djibouti	-	156,027
Ethiopia	295,450	445,979
Georgia	356,278	560,056
Haiti	-	168,682
Mozambique	425,733	657,997
Pakistan	121,413	445,363
Peru	308,141	179,543
Romania	204,062	200,127
Rwanda	582,872	484,183
South Sudan	910,388	986,956
Uganda	-	405,511
	<u>9,125,300</u>	<u>7,548,024</u>

Expenses per cost category:

Expatriate staff	2,438,106	2,558,236
National staff	2,321,030	1,770,526
Project administration costs	973,399	931,702
Transportation	999,414	737,282
Training/health education	537,866	362,614
Medical and other supplies	1,855,485	1,187,664
	<u>9,125,300</u>	<u>7,548,024</u>

The expatriate staff expenses include direct salary costs to an amount of Fl. 93,890 (1997: Fl. 132,600) related to staff which have been based at the Amsterdam office.

Notes to the Financial Statements

13 Office expenses (In Dutch guilders)

	1998	1997
Salary and social security costs	589,789	535,991
Pension costs	48,592	48,727
Other personnel costs	36,088	23,227
Office rent and utilities	70,888	68,258
Office supplies & services	89,590	90,135
Audit, advice and other costs	121,492	45,089
	<u>956,439</u>	<u>811,427</u>

14 Personnel

The Amsterdam office employs 8.8 staff in Full Time Equivalents at the end of 1998 (1997: 8.4 FTE's)
The administrators of the Board are not employed by the foundation and receive no remuneration.

Amsterdam, 5 May 1999

The Board of Administrators

Y. Baune, *chairman*

P.K.H. Meyer Swantée, *vice-chairman*

J. de Milliano, *secretary*

R.A.M.A. Keulen, *treasurer*

H.J. Meijman

A.M.F. Winkler

Auditor's Report

Introduction

We have audited the annual financial statements for the year 1998 of the Stichting HealthNet International, Amsterdam. These annual financial statements are the responsibility of the stichting's board. Our responsibility is to express an opinion on these annual financial statements based on our audit.

Scope

We conducted our audit in accordance with auditing standards generally accepted in the Netherlands. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the annual financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the annual financial statements. An audit also includes assessing the accounting principles used and significant estimates made by the board, as well as evaluating the overall presentation of the annual financial statements. We believe that our audit provides a reasonable basis for our opinion.

Opinion

In our opinion, the annual financial statements give a true and fair view of the financial position of the stichting as of 31 December 1998 and of the income and expenditure for the year then ended in according with accounting principles generally accepted in the Netherlands.

Amsterdam, 1 June 1999

KPMG Accountants N.V.

Colophon

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